NON-ACCIDENTAL INJURY TO CHILDREN

A Possible Treatment Programme

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While a great deal of effort has been directed toward the diagnosis of the battered child syndrome, perhaps Australia should direct the majority of its effort and money toward the implementation and evaluation of treatment programmes. It is proposed that the more effective treatment programme is based in the home of the family with initial daily home visits by the therapist to implement and teach proven techniques.

Researched

The battered child syndrome has been thoroughly discussed and researched as far as the diagnosis of child battering or non-accidental injury to children. The medical field, particularly Drs. Kempe and Helfer have been the leaders in the field and prime movers encouraging the establishment of treatment programmes to prevent recurrence of non-accidental injury to battered children. As a result of the increased study and emphasis on non-accidental injury, there exist several physical and psychological tests to be applied to children and their families to identify battered children and children at risk. What Australia needs to avoid at this time is the expenditure of a great deal of time, effort and money on diagnosing the battered child syndrome. Instead, the major emphasis here should be on implementing and evaluating various treatment programmes.

Mentally ill

Kempe and Helfer[1] have surmised that fewer than ten per cent of abused children have parents who are seriously mentally ill, i.e., psychotics or aggressive psychopaths. For the present there appears to be little hope of a successful treatment programme being implemented with these families that will reinstate the injured child and teach the parents successful parenting skills. Since there is a lack of technology available for teaching the psychotic appropriate parenting skills, there appears to be little value in pursuing treatment programmes for this minority of cases. The remaining ninety per cent of the families could possibly benefit from the application of demonstrably effective techniques that have been applied to different populations. For instance, if a parent abuses a child through an escalating attempt at discipline, why could that parent not be taught the procedures of time out, contingent attention and extinction, as described by numerous others as effective with children with behaviour problems.[2], [3], [4], [5]

Venue

The venue of any treatment programme may well be an essential variable in its success or failure. Regardless of what techniques are used it is often not enough to discuss the concepts and techniques in an office visit, no matter how regular the visits or how complete the discription. It is entirely possible that once at home, and under the pressure of a child who is acting out, the parents with the best intentions are likely to forget the concepts discussed in another setting and revert to measures he or she knows best, unless on-the-spot support and guidance is available. To implement any programme for teaching parents new parenting skills several factors are necessary:

1, Daily home visits by a therapist for an initial period of at least five days.

2. Modelling of procedures for the parents by that therapist
3. The presence of a therapist at the time of greatest stress
4. Twenty-four hour availability of the therapist
5. Follow-up procedures

Daily home visits by the therapist are required initially so that the family can learn to relax with the therapist present and accept the therapist as someone other than an intruder. Daily visits would also mean that there would be a continuity to the treatment in that no problem would be undiscussed for more than twenty-four hours. During the initial visits the therapist should be modelling and demonstrating the various techniques to be used by the parents. The therapist should be present when the parents experience their most trying times with children, e.g., if a child is troublesome waking up in the morning, the therapist should be there at that time. Likewise, if a family has problems at mealtimes, bedtime, nap time, etc. This obviously means the therapist must be prepared to work hours that do not fit into a roster. When the therapist is not at the family's home some method of reaching the therapist must be available to the family in the event of emergency. Such a method might well include an answering service like that used by physicians. In a crisis this will enable the family to have immediate information from a person that knows the entire family intimately.

Demonstrated

After the therapist has modelled and demonstrated the techniques to use, the therapist can have the parents implement these techniques and give the parents feedback on their performance of them. Over a short period of time the therapist can spend less time modelling and more time prompting the parents and giving them feedback on their performance. The next phase would be to spend less time in the home and to rely more on the telephone for advising the parents how to handle situations. Eventually the parents should be able to cope with, and manage their child with the techniques demonstrated by the therapist. Normally available aid from the community (e.g., homemakers, community welfare workers, etc.) could be implemented at this point. Periodic follow-up in the form of telephone contacts by the therapist and occasional visits may be necessary to prevent the parents from lapsing to previously used discipline techniques.

Treatment program

The treatment programme which is proposed enables parents to gain more satisfaction from their role as parents, as they would have been taught specific child management skills. As a result, the parents' discipline of their children would consist of using alternatives other than severe punishment, which may have been the sole discipline measure previously used.

Harassed parents

Many harrassed parents who are having difficulty in controlling their children tend to forego their recreational activities, either as a family or individually. This can produce a situation where parents become increasingly exhausted and frustrated with their parental role.

Therapist

The therapist should encourage the parent or parents to reinstate recreational time for themselves, so that the parents can be emotionally refreshed by having a break from their children, in turn having more energy to devote appropriately to the parenting role, rather than lapsing into previously learned inappropriate parenting methods. To aid this, the therapist could assist the parents to arrange contact with a babysitting service, so that these aims can be achieved.

Such a programme of treatment has many advantages over conventional treatment consisting of routine office counselling and sporadic home visits. First, this approach has been demonstrated to be more effective than traditional therapies with behaviour problem youths. [6,7], Second it gives the therapist a more thorough working knowledge of the family. Third, if the battered child requires, the programme can, and should be implemented while the child is still in hospital. Fourth, this can be implemented in conjunction with concurrent programmes such as therapy for the parents' personal problems or a homemaker to help with the management of the home. Fifth, such a programme would seek to break the cycle of lower socio-economic parents having few resources to deal with family problems and sending their children into the world with an inadequate model for bringing up their own offspring, producing another generation of abused and neglected youths. Sixth, in the event of failure of the family to respond, a thorough and complete report of the family dynamics, reasons for failure, and recommendations can be made by a therapist having implemented this programme.

Time and money

In terms of time and money the programme described would be costly to implement. It is conceivable that each therapist spend approximately a month to six weeks with one family only.

Research

Certainly, research as to the cost effectiveness of such a programme should be undertaken before widespread dissemination is implemented. The question also remains as to whether such im-

plementation is the responsibility of the hospital diagnosing and admitting non-accidentally injured children or the statutory authority under whose legal jurisdiction the family fall. Some families may need a therapy entirely different from this; perhaps aimed only at the parents' problems or based on different techniques. What is clear is that enought has been done worldwide on diagnosing and delineating the problem of child abuse; what is needed in Australia is a viable treatment programme for these families.

References:

1. Kempe, H. C. & Helfer, R. E. *Helping the battered child and his family.* Philadelphia: J. B. Lippincott Co., 1972.
2. Bernal, M. E., Behavioural feedback in the modification of brat behavious. *Journal of Nervous and Mental Disease, 1969.*
3. Hawkins, R. P., Peterson, E. F., Schwied, E. and Bijou, S. W. Behaviour therapy in the home: amelioration of problem parent-child relations with the parent in the therapeutic role. *Journal of Experimental Child Psychology, 1966.*
4. Wolf, M. M., Giles, D., Hall, R. V., Experiments with token reinforcement in a remedial classroom. *Behaviour Research and Therapy, 1968.*
5. Risley, T., The effects and side effects of punishing the autistic behaviours of an autistic child. *Journal of Applied Behaviour Analysis, 1968.*
6. Christophersen, E. R., Barnard, J. D., Ford, D. & Wolf, M. M. The Family Training Programme: Improving Parent-Child Interaction Patterns. In Mash, E. J., Handy, L.C., & Hamerlynch, L.A., *Behaviour Modification and Families:* 11. Applications and Developments. New York: Brunner Mazel, Inc., 1975.
7. Ford, D. & Kennedy, R., Treatment in Residential Care: A Case Study. *Australian Child × Family Welfare.* 1, 3, 1976.